EXECUTIVE SUMMARY

PURPOSE

This report examines differences in the reimbursement methodologies used by the Medicare and Medicaid programs to pay for prescription drugs, focusing on three inhalation drugs used in nebulizers.

BACKGROUND

Medicare does not generally pay for outpatient prescription drugs. However, there are several exceptions to this general rule, including payment for drugs used in conjunction with medical equipment. For such drugs, Medicare computes an allowed amount based on the lower of the Estimated Acquisition Cost (EAC) or the national Average Wholesale Price (AWP). The allowed amount is the price that Medicare and its beneficiaries pay a drug supplier. If a drug has multiple sources, price is based on the lower of the EAC or the median of the national AWP for all generic sources.

The Medicaid program provides coverage for outpatient prescription drugs as an optional benefit. Currently, all States provide coverage for outpatient prescription drugs. Medicaid payment policies for such drugs vary across States, within guidelines established by the Health Care Financing Administration (HCFA). Many States discount the AWP to set drug prices. The Medicaid program, in addition, uses a rebate program to obtain discounts from pharmaceutical manufacturers.

In this report, we compare Medicare and Medicaid costs in 17 States for three drugs used in conjunction with nebulizers by Medicare beneficiaries from January 1994 through February 1995. A nebulizer is a medical device which administers drugs for inhalation therapy for patients with respiratory conditions such as asthma or emphysema. Medicare allowed amounts (which include 20 percent copayments by beneficiaries) for nebulizer drugs remained relatively stable between 1990 and 1992, never exceeding $74 million. Allowed amounts increased to $170 million in 1993 and $226 million in 1994, more than a 200 percent increase from 1990.

FINDINGS

Medicare and its beneficiaries paid about $37 million more for three nebulizer drugs in 17 States than the amount that Medicaid would have paid for equivalent drugs.

> We found that over $11.7 million of the higher costs are attributable to the method Medicare employs to determine prices paid to drug suppliers, and about $25.3 million is due to the lack of a manufacturers' rebate program, similar to Medicaid's.

Potential Medicare savings are not restricted to the three nebulizer drugs and 17 States reviewed.

Because of inherent differences in the reimbursement methodologies followed by Medicare and Medicaid, the potential cost savings available to Medicare are not, in our opinion, restricted to either the three drugs or the 17 States included in our review. For instance, if Medicare had revised its drug pricing methodology and implemented a manufacturers' rebate program, it and its beneficiaries could have saved about $58 million of the $226 million allowed for nebulizer drugs (excluding administrative costs) in 1994.

Medicare also allowed more than $1 billion for other drugs in 1994. We estimate that Medicare and its beneficiaries could have saved about $83 million for these drugs had Medicare's drug pricing methodology been revised. Furthermore, had there been a drug rebate program in effect, the estimated savings could have increased even more substantially.

RECOMMENDATIONS

We recommend that HCFA reexamine its Medicare drug reimbursement methodologies with a goal of reducing payments as appropriate.

Our study demonstrated that Medicare could have saved millions by discounting the wholesale price and establishing a rebate program. We recognize, however, that other cost saving options are available. One or more of the following options should be aggressively pursued to save Medicare funds and to place this program on par with Medicaid and other payers in obtaining competitive pricing for prescription drugs.

Discounted Wholesale Price

Many State agencies use a discounted AWP to establish drug prices. Medicare should have a similar option. Medicare could base its drug payment on the lower of a discounted AWP or the median of the AWP for all generic sources, whichever results in the lower cost to Medicare and its beneficiaries. To implement this recommendation, HCFA would have to revise Medicare's claims coding system which does not identify the manufacturer or indicate if the drug is a brand name or a generic equivalent, information that is needed to discount the AWP and obtain a rebate for a specific drug. Medicaid uses the National Drug Code (NDC) in processing drug claims. The NDC identifies the manufacturer and reflects whether the drug is a brand name or a generic equivalent.

Manufacturers' Rebates

Medicare could develop a legislative proposal to establish a mandated manufacturers' rebate program similar to Medicaid's rebate program. We recognize that HCFA does not have the authority to simply establish a mandated manufacturers' rebate program

similar to the program used in Medicaid. Legislation was required to establish the Medicaid rebate program, and would also be required to establish a Medicare rebate program. We have not thoroughly assessed how a Medicare rebate program might operate, what administrative complexities it might pose, or how a Medicare rebate program might differ from a Medicaid rebate program. We believe, however, the legislative effort would be worthwhile. The same manufacturers that provide rebates to Medicaid make the drugs that are used by Medicare beneficiaries and paid for by the Medicare program.

Competitive Bidding

Medicare could develop a legislative proposal to allow it to take advantage of its market position. While competitive bidding is not appropriate for every aspect of the Medicare program or in every geographic location, we believe that it can be effective in many instances, including the procurement of drugs. Medicare could ask pharmacies to compete for business to provide Medicare beneficiaries with prescription drugs. All types of pharmacies could compete for Medicare business, including independents, chains, and mail-order pharmacies.

Inherent Reasonableness

Since Medicare's guidelines for calculating reasonable charges for drugs result in excessive allowances, the Secretary can use her "inherent reasonableness" authority to set special reasonable charge limits. If this option is selected, however, it will not be effective unless the Secretary's authority to reduce inherently unreasonable payment levels is streamlined. The current inherent reasonableness process is resource intensive and time consuming, often taking two to four years to implement. Medicare faces substantial losses in potential savings--certainly in the millions of dollars--if reduced drug prices cannot be placed into effect quickly.

Acquisition Cost

Medicare could base the payment of drugs on the EAC. The Durable Medical Equipment Regional Carriers (DMERCs) currently have this option; however, HCFA has been unsuccessful in gathering the necessary data to fully implement it. Once the problem of gathering the necessary data is overcome, the use of the EAC would result in lower allowed amounts.

Our work regarding drugs reimbursed by Medicare is continuing. We will explore reasons for the sharp increase in reimbursement for nebulizer drugs that occurred in 1993 and 1994. We will also determine the actual prices drug suppliers pay for nebulizer drugs. Finally, we will examine other drugs Medicare reimburses to ensure that they are properly priced, and to validate our premise that the differences inherent in the reimbursement methodologies of Medicare and Medicaid cause Medicare to pay more for drugs than Medicaid, regardless of the type of drug or where Medicare beneficiaries reside.

AGENCY COMMENTS

The HCFA concurred with our recommendation and is currently examining available options in an effort to make appropriate drug payment reductions. The HCFA expects by early 1996 to reach a decision on whether to proceed with a legislative proposal or to revise current regulations. The full text of HCFA's comments can be found in Appendix B.